CENTERSTON	WIEDICARE & WEDIC	AID SERVICES			ONIB 110: 0200 0031	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155742	B. WING		05/27/2011	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	ŧ.	1400 L	AMMERS PIKE		
ST ANDF	REWS HEALTH CAI	MPUS		VILLE, IN47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, and the second se	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000	m1 · · · ·	6 4	F0000	R117 Personnel1. Staff;		
	This visit was	for the	F0000	CNA's #1, 2, 3, 4, 7, LPN #5		
	Recertification	n and State Licensure		QMA #6 and the Activity Dire		
	Survey.			will be trained on First Aid by		
	Sarvey.			1, 2011.2. all other staff that		
				scheduled on Residental File	es	
	Survey dates:	May 23, 24, 25, 26,		were reviewed to assure cur	l l	
	and 27, 2011			first aid by the Director of He		
	,			Services/Designee by July 1		
	D 1114 1	004671		2011.3. All Depart Leaders Include Payroll were inservice		
	Facility numb	er: 0046/1		on the policy on First aid trai	I	
	Provider numb	per: 155742		by Director of Health	9	
	AIM number:	200538760		Services/Designee by July 1	,	
	THIN HAIROUT.	200330700		2011.4. Director of Health		
				Services or Designee will mo	onitor	
	Survey team:			all employee files that work		
	Penny Marlatt	, RN, TC		Residental to assure continu	·	
	Diana Sidell, I	<i>'</i>		education in first aid. These audits will be ongoing. All re	l l	
	· ·			will be reviewed by the QA	Journal	
		r, RN (May 24, 25,		committee to assure complia	ance.	
	26, and 27, 20	11)		·		
	Barbara Grav.	RN (May 25, 26, 27,				
	2011)					
	2011)					
	Census bed ty	pe:				
	SNF: 5	_				
	SNF/NF: 43					
		_				
	Residential: 3	52				
	Total: 80					
	Comana	tr. 10 0 1				
	Census payor	type:				
	Medicare: 8					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671

TITLE

If continuation sheet

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE	Y
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	
155742 B. WING - 05/27/2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1400 LAMMERS PIKE	
ST ANDREWS HEALTH CAMPUS BATESVILLE, IN47006	
PROVIDER'S PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
	ATE
Medicaid: 19	
Other: 53	
Total: 80	
Sample: 12	
Supplemental sample: 2	
Residential sample: 7	
These deficiencies also reflect state	
findings cited in accordance with	
410 IAC 16.2.	
Quality review completed 6/6/11	
Cathy Emswiller RN	
Catily Liniswiner Riv	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

004671

Facility ID:

If continuation sheet

Page 2 of 36

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROSS-REFERENCED TO THE APPROPRIATE DATE A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident slegal representative or an interested family member when there is an accident involving the resident herealth results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in \$483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician for a continuation of a previous order for supplemental oxygen therapy for 1 of 12 residents reviewed for oxygen therapy.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155742			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A facility must immediately interested family member when there is an accident income an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident family member when there is a change in resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident's plone or interested family member when there is a change in room or roommate assignment as specified in §483.12(a). The facility must also promptly notify the resident's plone or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician for a continuation of a previous order for supplemental oxygen therapy for 1 of 12 residents reviewed for oxygen therapy.				1400 LA	AMMERS PIKE	
resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician for a continuation of a previous order for supplemental oxygen therapy for 1 of 12 residents reviewed for oxygen therapy.	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETION DATE
Based on interview and record review, the facility failed to notify the physician for a continuation of a previous order for supplemental oxygen therapy for 1 of 12 residents reviewed for oxygen therapy. F0157 F157 Notify of Changes1. Resident #20 oxygen has been discontinuted.2. All residents receiving oxygen's clinical record will be reviewed by DHS or designee to assure current		resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuc conditions or clinical ter treatment significant conditions or clinical terms for discontinue an existic paraser or discharfacility as specified. The facility must a resident significant conditions or clinical terms for consequence of the second conditions or clinical terms for clinical terms for conditions or clinical terms for conditions or clinical terms for clinical terms for conditions or clinical terms for clinical terms fo	with the resident's physician; by the resident's legal an interested family member accident involving the ults in injury and has the ing physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening and complications); a need to inficantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the drin §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or entrights under Federal or ations as specified in of this section.			
(Resident #20) (Resident #20) Findings include: physician orders by July 1, 2011.3. Nurses have been re-inserviced on admission process with emphasis on physician orders by		Based on intervie facility failed to a continuation of a supplemental oxy residents reviewe (Resident #20)	notify the physician for a previous order for ygen therapy for 1 of 12 ed for oxygen therapy.	F0157	Resident #20 oxygen has be discontinuted.2. All residents receiving oxygen's clinical rewill be reviewed by DHS or designee to assure current physcian orders by July 1, 20 Nurses have been re-inservicion admission process with	cord 011.3. ced

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671

If continuation sheet

Page 3 of 36

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155742	A. BUI		00	05/27/2	
		100742	B. WIN		A DDDEGG CITY GTATE ZID CODE	00/21/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ST ANDF	REWS HEALTH CAN	//PUS		1	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	44.4	DATE
	Resident #20's clareviewed on 5-26 diagnoses include to left lower lobe 2011), diabetes in (high blood press chronic kidney diartery disease. Resident #20 had area hospital 3-22 with the above in pneumonia. The clinical record to the facility on documentation or order for oxygen documented the readmission asse 2330 (11:30 p.m. LPM (liters per in cannula with the 93%. Nursing as 1:15 a.m., 3:00 a	inical record was 5-11 at 10:30 a.m. Her ed, but were not limited pneumonia (March nellitus, hypertension sure), osteoarthritis, isease and coronary			DHS/designee by July 1, 20 All admit/readmit records shareviewed by DHS or designed during CQI meetings for according of orders. This audit is ongo	all be e uracy	
	_	.m. and on the 2:00 p.m.					
	1	ft (no specific time					
	l '	4-4-11 at 5:50 a.m.					
		listed indicated the					
	oxygen was at 2	LPM.					
		the Director of Health on 5-26-11 at 12:02 p.m.,					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011
	PROVIDER OR SUPPLIER		1400 LA	ADDRESS, CITY, STATE, ZIP CODE AMMERS PIKE VILLE, IN47006	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	kept in the hospi hours that the fac physician orders return to the faci the DHS on 5-26 indicated the fac locate any orders oxygen after she hospital (in Marc the resident had	t any time a resident is tal for more than 24 cility always gets all new for that resident upon lity. In interview with 5-11 at 12:30 p.m., she ility had been unable to a for (supplemental) returned from the ch 2011.) She indicated (physician) orders for her hospitalization.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155742	B. WING		05/27/2011
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	L	I	AMMERS PIKE	
ST ANDF	REWS HEALTH CAN	MPUS	I	VILLE, IN47006	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225		ot employ individuals who			
have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to					
	the State nurse aid	de registry or licensing			
	authorities.				
		ensure that all alleged			
	1	g mistreatment, neglect, or njuries of unknown source			
		ion of resident property are			
		tely to the administrator of			
		other officials in accordance			
		ough established procedures			
		tate survey and certification			
	agency).				
	The facility must h	ave evidence that all			
		are thoroughly investigated,			
		further potential abuse while			
	the investigation is				
		nvestigations must be			
		ministrator or his designated			
		d to other officials in State law (including to the			
		certification agency) within 5			
		e incident, and if the alleged			
		d appropriate corrective			
	action must be taken.				
	Based on record review and interview, the		F0225	F225 Investigate/Report	07/01/2011
facility failed to ensure all allegations of			Allegations/Individuals1.		
	abuse or misappr	ropriation of resident		Residents #21, #44, & # 45 Allegations have been review	wed
	property were rep	ported to the State Survey		by state Agency on 5/25/112	. All
	and Certification	Agency in that one		other concern forms have be	en

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155742	B. WIN	IG		05/27/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	AMMERS PIKE		
STANDE	REWS HEALTH CAN	MPUS		BATES	VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		,		IAU	reviewed by Executive Direct	tor to	DATE
		to resident roughness and of missing property were			assure anyother allegations		
	not reported. Th				been reported as per regula		
	residents reviewe				by July 1, 2011.3. Executive	;	
		of property in a sample			Director, Director of Health Services, Social Services ar	nd all	
	of 12 and 1 of 2 i				other Department Leaders h		
		nple of 2. (Residents			been re-inserviced on the Po		
	#21, #44, and #4	•			related to reporting of all	and	
	$\frac{\pi 21}{\pi}$, and $\frac{\pi 4}{\pi}$	~ <i>)</i>			allegations to state agency a APS by clinical support/design		
	Findings include				by July 1, 2011.4. All conce		
	Tindings include	•			forms will be reviewed by		
	An "Abuse Polic	y" with a last review	Executive Director/designee to				
	An "Abuse Policy", with a last review date of 12/29/10, was provided by the				assure compliance. Audits of continue until 100% complia		
	· ·	Director on 5/25/11 at			reached times three consecu		
		policy included, but was			months. All results will be		
	1 ^	Frilogy Health Services,			reviewed by QA committee a need for further auditing will		
	LLC (THS), has	•			determined by the committe		
	` ''	cesses, which strive to			, , , , , , , , , , , , , , , , , , , ,		
	1 ^ ^	ntion and reporting of					
	_	ged resident abuse and					
	_	TTIONSPhysical Abuse					
	1 ~	, slapping, pinching,					
	1	or handling roughly,					
	1 2	iation of Property -					
	includes, but is n	2 2					
	deliberate misplacement, exploitation, or						
	· ·	rary or permanent use of					
		ngings or funds6.					
		eporting - the Executive					
	_	ector of Health Services					
	are accountable f	For investigating and					
		fer to the Incident and					
		n for investigation					
	procedures"	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671

If continuation sheet

Page 7 of 36

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155742	A. BUI	LDING	00	05/27/2	
		100742	B. WIN			03/21/2	J 11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ST ANDE	REWS HEALTH CAN	MPUS		1	VILLE, IN47006		
					VILLE, IIVII 000		(X5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TION SHOULD BE CO	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION DATE
		,					
	A policy for "Ac	cidents and Incidents;					
	Reports, Investigations, Follow-up and						
	* '	h a last review date of					
		ovided by Employee					
		ords on 5/23/11 at 2:58					
		indicated, but was not					
		To assure that the					
	· ·	dent/incidents may					
		•					
	include, but are not limited to the followingAbuse or suspected						
	abusePROCEDURE: 1. Should an						
		occur, THS strives to					
		occurrences. A thorough					
	1 ^	follow-up will be					
	completed within	•					
	1 1	rences where there is					
		atment, neglect, abuse, or wn origin will be					
	"	•					
	1 .	orted to the Director of and Executive Director.					
	_	officials/agencies will be					
	made m accordar	nce with State Law"					
	A notion for "D	vantion and Danastina of					
	1 ^ -	evention and Reporting of					
	_	ent Abuse and Neglect",					
		v date of 12/29/10, was					
	1	bloyee #9/Medical					
		11 at 2:58 p.m. The					
	* *	but was not limited to,					
	"b. 24 hour ini						
	1 * *	genciesd. A written					
	1 ^	estigation outcome,					
	including residen	t response and/or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155742		LDING	00	05/27/2	
		100742	B. WIN		A DDDEGG CITY CTATE ZID CODE	00/2//2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
ST ANDF	REWS HEALTH CAN	MPUS		1	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	πE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	l '	onclusion and actions					
	taken to prevent reoccurrence, will be						
	submitted to the applicable State Agencies within five days" 1. Resident # 21's record was reviewed						
	on 5/27/11 at 4:2	0 p.m. The record					
		nt #21 was admitted with					
	diagnoses that in	cluded, but were not					
	limited to, arthritis, osteoporosis, left hip pain, and increased weakness.						
		inimum Data Set (MDS)					
		d 9/22/11 indicated					
	Resident #21 had	-					
	1 ^	no long term or short					
	term memory pro	oblems.					
	A "Resident Con	cern Form" dated 2/23/11					
	indicated Resider	nt #21 had a concern of					
	"unnecessary rou	ghness during transfer"					
	on the late evening	ng of 2/22/11. The form					
	indicated the leve	el of resident's					
	dissatisfaction wa	as "upset", the					
	occurrence would	d be investigated, and "so					
		s not reoccur, reeducate,					
	·	ervice" would be done.					
		n of "Resolution and					
	Communication"						
		was done with the					
		11 and included: "DHS					
	`	th Services) spoke [with]					
		nseled staff apologized to					
	resident for perce	eption"					

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155742		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 05/27/2	LETED	
	PROVIDER OR SUPPLIER		1400 LA	ADDRESS, CITY, STATE, ZIP CO AMMERS PIKE VILLE, IN47006	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	dated 2/23/11 incomplaints that 0 while giving assivia mech [mechathat personnal (sment." (sic) Thias a verbal warn disciplinary action. During an interval.m., the Social Sindicated this incomplaints	Counseling Record Form" dicated: "Resident QMA was rude and rough istants (sic) to toileting anical] lift. Resident felt sic) needs were not s form was documented ing for the type of on. iew on 5/27/11 at 10:15 Services Director cident had not been adiana State Department				
	5/25/11 at 3:52 p Resident #45 wa diagnoses that in limited to, high to diabetes mellitus osteoporosis. A quarterly MDS 3/30/11 indicated moderately cogn short term and to problems.	cluded, but were not blood pressure, stroke, s, arthritis, and S assessment dated d Resident #44 was attively impaired and had ong term memory				
		acern Form" dated 11/8/10 ern of lost money, "\$60				

004671

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155742	B. WIN			05/27/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				AMMERS PIKE	
	REWS HEALTH CAN	MPUS		1	VILLE, IN47006	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	missing over last several weeks." This					
	incident was investigated and family					
	notified.					
	A "Resident Con	cern Form" dated 5/10/11				
	at 4:40 p.m. indi	cated a concern of lost				
	property: "4 - \$	100 bills, check for				
		dent was investigated and				
	family notified.	8				
	, , , , , , , , , , , , , , , , , , , ,					
	 During an intervi	iew on 5/27/11 at 3:18				
	~	ive Director indicated				
	* ·	ad not been reported to				
		•				
		Department of Health.				
		new for sure the money				
	I -	ould report to ISDH for				
	misappropriation	of funds. With him I'm				
	not sure that he a	ictually has money				
	missing."					
	3. Resident #45	s record was reviewed on				
		.m. The record indicated				
	Resident #45 was					
		cluded, but were not				
	•	a, degenerative joint				
	· ·					
	uisease, osteoarti	hritis, and insomnia.				
	A quarterly MDS assessment dated					
		l Resident #45 had no				
		ment and no long or short				
	term memory pro	oblems.				
	A "Resident Con	cern Form" dated 11/8/10				

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	li i	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		1400 LA	ADDRESS, CITY, STATE, ZIP CO AMMERS PIKE VILLE, IN47006	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	provided by the son 5/27/11 at 10: concern of lost p 18 inch TV. The "Interviewed all seeing it but assu (home) when browners [name of mentioned giving facility]. TC (tel [another facility] have TV per TC Searched all res[items for facility [with] res[ident] satisfied [with] in resolution." A "Resident Con 12/30/10 at 11:00 of lost property; an envelop in a sout of Rm for 1-afternoon." This investigated and notified. During an interval	ident] rooms storage of - not located. Spoke & fam[ily]. They are nvestigation. No cern Form" dated 0 a.m. indicated a concern "\$45 worth of #5 bills in hoe box on her bed - was 1 1/2 hr 12/29 s incident was police and family were				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155742 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1400 LAMMERS PIKE ST ANDREWS HEALTH CAMPUS BATESVILLE, IN47006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1-28(a)F0226 The facility must develop and implement written policies and procedures that prohibit SS=D mistreatment, neglect, and abuse of residents and misappropriation of resident property. F0226 F226 Development/Implement 07/01/2011 Abuse/Neglect, etc. policies1. Based on record review and interview, the Resident #21, #44 & #45 facility failed to implement the abuse allegations have been reviewed policy and procedures related to reporting by state agency on May 25, 2011.2. All other concern forms alleged occurrences of abuse or have been reviewed by the misappropriation of residents property to Exective Director to assure any the State Agency in that one incident of other allegations have been staff to resident roughness and four reported as per regulation by July 1. 20113. Executive Director. incidences of missing property were not Director of Health Services and reported. This affected 2 of 3 residents all other department leaders have reviewed for implementation of the abuse been re-inserviced on policy policies in a sample of 12 and 1 of 2 related to reporting of all residents in a supplemental sample of 2. allegations to state agency and APS by clinical support/designee (Residents #21, #44, and #45) by July 1, 2011.4. All concern forms will be reviewed by the Findings include: Executive Director/Designee to assure compliance. Audits will continue until 100% compliance is An "Abuse Policy", with a last review reached times three consecutive date of 12/29/10, was provided by the months. All results will be Social Services Director on 5/25/11 at reviewed by QA committee and 10:15 a.m. The policy included, but was need for further auditing will be determined by committee. not limited to, "Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to

004671

STATEMEN	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155742	B. WIN			05/27/2011
NAME OF I	DROVADED OD GLIDDI IED				ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF F	PROVIDER OR SUPPLIER			1400 LA	AMMERS PIKE	
	REWS HEALTH CAN				VILLE, IN47006	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DETICIENC!)	DATE
		ntion and reporting of				
	suspected or alleged resident abuse and					
	neglectDEFINITIONSPhysical Abuse					
	- includes hitting, slapping, pinching,					
	1	or handling roughly,				
		iation of Property -				
	includes, but is n	•				
	deliberate misplacement, exploitation, or					
	wrongful, temporary or permanent use of					
	a resident's belongings or funds6.					
	Investigation / Reporting - the Executive					
	Director and Director of Health Services					
	are accountable for investigating and					
	reporting. a. Re	fer to the Incident and				
	Accident Prograi	m for investigation				
	procedures"					
	A policy for "Ac	cidents and Incidents;				
	Reports, Investig	gations, Follow-up and				
	Disposition", wit	th a last review date of				
	12/29/10, was pr	ovided by Employee				
	_	ords on 5/23/11 at 2:58				
	p.m. The policy	indicated, but was not				
	1	To assure that the				
		ident/incidents may				
	include, but are r	-				
	followingAbus					
	1	OURE: 1. Should an				
		t occur, THS strives to				
		occurrences. A thorough				
	1 -	I follow-up will be				
	completed within	_				
	_	rrences where there is				
		atment, neglect, abuse, or				
	L suspected initiation					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155742	A. BUII		00	05/27/2	
		1007 12	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/21/2	
NAME OF I	PROVIDER OR SUPPLIER				AMMERS PIKE		
ST ANDF	REWS HEALTH CAN	MPUS		1	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	"	wn origin will be					
	, ,	orted to the Director of					
		and Executive Director.					
	Reports to other officials/agencies will be						
	made in accordance with State Law"						
	A policy for "Prevention and Reporting of						
	Suspected Resident Abuse and Neglect",						
	1 *	v date of 12/29/10, was					
		*					
	provided by Employee #9/Medical Records on 5/23/11 at 2:58 p.m. The						
	policy included, but was not limited to,						
	"b. 24 hour initial reporting to						
		genciesd. A written					
		estigation outcome,					
	1 ^	•					
	·	nt response and/or					
	· ·	onclusion and actions					
		reoccurrence, will be					
		applicable State Agencies					
	within five days.	"					
	1. Resident # 21	's record was reviewed					
		0 p.m. The record					
		nt #21 was admitted with					
		cluded, but were not					
	· -	is, osteoporosis, left hip					
	pain, and increas						
	pani, and mercas	ou weariess.					
	An admission M	inimum Data Set (MDS)					
		d 9/22/11 indicated					
	Resident #21 had						
		no long term or short					
	term memory pro	-					
	, , , , , , , , , , , , , , , , , , ,						
					<u> </u>		

AND PLAN OF CORRECTION 155742 NAME OF PROVIDER OR SUPPLIER STANDREWS HEALTH CAMPUS X(A) ID SUMMARY STATEMENT OF DEPICIENCIES (FACH DEPICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication, as done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseld staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment." (sic) This form was documented as a			X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER STANDREWS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
A "Regulatory or local communication", a date of communication", a date of communication was done with the resident or 2/23/11 aindicated: "Resolution and Communication", a date of communication was done with the resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident (sic) to toileting via mech[anical] lift. Resident (sic) present a personnal (sic) needs were not ment."			100742	B. WIN			03/21/2	011
ST ANDREWS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PERCEDED BY FULL TAG (FOR DEPICIENCY) A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."	NAME OF P	PROVIDER OR SUPPLIER			1			
CX4 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS ILANO CORRECTION (EACH ODRIGHCH IN ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseld staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."	ST VNDE	DEVAC HEALTH CAN	ADI IS		1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATIONY OR LSC (DENTIFYTING INFORMATION)) A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."					L	VILLE, IN47000		
A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
A "Resident Concern Form" dated 2/23/11 indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		`				CROSS-REFERENCED TO THE APPROPRIA	ΓE	
indicated Resident #21 had a concern of "unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."	mo		,	-	1710	<u> </u>		DATE
"unnecessary roughness during transfer" on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
on the late evening of 2/22/11. The form indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
indicated the level of resident's dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		•	-					
dissatisfaction was "upset", the occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."			~					
occurrence would be investigated, and "so the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
the situation does not reoccur, reeducate, counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."			* '					
counsel, and inservice" would be done. Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."			•					
Under the section of "Resolution and Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
Communication", a date of communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		1 '						
communication was done with the resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
resident on 2/23/11 and included: "DHS (Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		·						
(Director of Health Services) spoke [with] res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
res & staff - counseled staff apologized to resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
resident for perception" An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		· ·						
An "Employee Counseling Record Form" dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		resident for perce	eption					
dated 2/23/11 indicated: "Resident complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."		An "Employee C	ounceling Record Form"					
complaints that QMA was rude and rough while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
while giving assistants (sic) to toileting via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."								
via mech[anical] lift. Resident felt that personnal (sic) needs were not ment."			`					
personnal (sic) needs were not ment."								
T CANAL THIS TOTAL WAS ADMAHRAHALIAS A TOTAL TOT		` ′						
verbal warning for the type of disciplinary		· /						
action.		_	or the type of disciplinary					
		action.						
During an interview on 5/27/11 at 10:15		During an intervi	iew on 5/27/11 at 10·15					
a.m., the Social Service Director indicated		-						
that this incident had not been reported to		· · · · · · · · · · · · · · · · · · ·						
the Indiana State Department of Health.			_					
the Indiana State Department of Health.		The merana state	Department of Hearth.					
2. Resident #44's record was reviewed on		2. Resident #44's	s record was reviewed on					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155742	B. WIN			05/27/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	₹			AMMERS PIKE		
ST AND	REWS HEALTH CA	MPUS			VILLE, IN47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	5/25/11 at 3:52 p	o.m. The record indicated					
	Resident #45 wa	s admitted with					
	diagnoses that included, but were not						
	limited to, high blood pressure, stroke,						
	diabetes mellitus, arthritis, and						
	osteoporosis.						
	osteoporosis.						
	A quarterly MDS assessment dated						
	3/30/11 indicated Resident #44 was						
	moderately cognitively impaired and had						
	short term and long term memory						
	problems.						
	A "Resident Concern Form" dated 11/8/10						
		ern of lost money, "\$60					
	1	t several weeks." This					
	1 -						
	1	estigated and family					
	notified.						
	A "Resident Cor	ncern Form" dated 5/10/11					
		cated a concern of lost					
	1 -	100 bills, check for					
	1	ident was investigated and					
	family notified.	done was investigated and					
	laminy nounced.						
	During an interv	iew on 5/27/11 at 3:18					
	1 -	ive Director indicated					
	1 ^	ad not been reported to					
		Department of Health.					
	1	new for sure the money					
	1	ould report to ISDH for					
	1	_					
		n of funds. With him I'm					
		actually has money					
	missing."						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	l` ´	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		1400	EET ADDRESS, CITY, STATE, ZIP O O LAMMERS PIKE ESVILLE, IN47006	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	5/27/11 at 8:55 a Resident #45 wa diagnoses that in limited to, anemi disease, osteoarth A quarterly MDS 3/24/11 indicated cognitive impair term memory pro A "Resident Con at 11:01 (no a.m. provided by the on 5/27/11 at 10: concern of lost p 18 inch TV. The "Interviewed all seeing it but assu (home) when bro Nurse [name of 1 mentioned giving facility]. TC (tel [another facility] have TV per TC Searched all res[items for facility [with] res & fam [with] investigat	cluded, but were not a, degenerative joint hritis, and insomnia. S assessment dated I Resident #45 had no ment and no long or short oblems. cern Form" dated 11/8/10 or p.m. on the form) was Social Services Director 15 a.m. and indicated a roperty, a Samsung LCD e investigation included: staff - reports they recall med fam. took hm ought in her 52" TV. nurse] reported [Resident] g it to a friend at [another ephone call) made to . Friend - [name] did not				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155742	B. WING		05/27/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE AMMERS PIKE	
	REWS HEALTH CAN			VILLE, IN47006	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE
		0 a.m. indicated a concern			
		"\$45 worth of #5 bills in			
	an envelop in a shoe box on her bed - was out of Rm for 1 - 1 1/2 hr 12/29				
	afternoon." This				
	_	police and family were			
	notified.				
	During an interview on 5/27/11 at 10:15				
	a.m., the Social Services Director indicated these two incidents had not been reported to the Indiana State Department of Health.				
	oi meaiui.				
	2.1.20()				
	3.1-28(a)				
F0282	The services provi	ided or arranged by the			
SS=D	facility must be pro	ovided by qualified persons			
		n each resident's written			
	plan of care.	adian todan to 1	F0202	E292 Sarviosa by gualified	07/01/0011
		ation, interview and	F0282	F282 Services by qualified persons/per care plan1. On	07/01/2011
	· · · · · · · · · · · · · · · · · · ·	ne facility failed to ensure		5-26-2011 The Director of He	
		owing the physician's		Services or designee review	ed
		r care in regard to:		medical records for residents	s # 9
	•	dication to be given on a		& #30. a. Resident #9:	
	weekly basis for	1 of 2 supplemental		medication error report was completed for 5-17-11 on	
				Completed for 5-17-11 off	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155742	B. WIN			05/27/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEF	8		1	AMMERS PIKE		
ST AND	REWS HEALTH CAI	MPUS		1	VILLE, IN47006		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	ŧ	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		reviewed for medication			5-24-11. Resident received proper dose of medication or	,	
	accuracy. (Resid				5-24-11. MD and family notif		
	2. providing an inaccurate dosage of				of Medication error. b. Resi		
	medication for 1	of 2 supplemental			#30: medication error report		
	residents review	ed for medication			completed, MD and family		
	accuracy. (Resid	dent #30)			notified. New label with corre		
					dosage was placed on medic on 5-25-11.2. Director of He		
	Findings include	:			Services or designee will	aitii	
					compare all MAR's with origin	nal	
	1. During the m	edication pass			MD orders on all residents by		
	_	-24-11 at 7:25 a.m., LPN			1, 2011.3. Director of Health		
	#1 was observed providing the morning				Servies or designee will		
					re-inservice all nurses to incl LPN #1, #2 & QMA's on	uae	
	medications to Resident #9. After the				medication policy with empha	asis	
		rvation was completed, a			on the five rights of medication		
		nciliation was conducted			pass to minimize error by Jul	y 1,	
	_ ·	edications were given in			2011.4. Ten MAR's per week	will	
	_	hat medications had been			be compared with physician		
	1 .	hysician. The physician			orders to assure medications received as ordered. Audits		
	orders indicated	Resident #9 was to			continue until 100% compliar		
	receive Vitamin	D-2 50,000 units once			reached times three consecu		
	weekly by moutl	h. On the Medication			months. All results will be		
	Administration F	Record (MAR) this			reviewed by QA committee a		
	medication was i	identified to be given			need for further auditing will determined by committee.	be	
	each Tuesday up	on rising. This			determined by committee.		
		not identified as being					
		5-17-11 as the date had					
		to identify which date to					
		medication; however, the					
	1 -	with no one's initials					
		e box to indicate it had					
	1 ^	ed. A "Medication Error					
	_	-24-11 indicated Vitamin					
	1	1 capsule orally once					
	weekly on Tueso	lays had been omitted on	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155742		A. BUILI	DING	NSTRUCTION 00	(X3) DATE COMPI 05/27/2	LETED	
		199742	B. WING		DDRESS, CITY, STATE, ZIP CODE	03/21/2	:011
NAME OF I	PROVIDER OR SUPPLIER				MMERS PIKE		
ST AND	REWS HEALTH CAN			BATES\	/ILLE, IN47006		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	5-17-2011.						
	2. During the mo	•					
	observation on 5-25-11 at 11:35 a.m.,						
		erved providing the noon					
		esident #30. LPN #2					
	was observed administering 5 milliliters						
	of Xyloxin liquid to Resident #30 prior to						
	her meal.						
	After the medication observation was						
	completed, a medication reconciliation						
	was conducted to verify what medications						
		mparison to what					
	_	been ordered by the					
		physician orders indicated					
	1 ^ -	:55 a.m. a clarification					
		the Xyloxin to 2 tsp.					
		milliliters) by mouth					
		5 minutes before meals					
	1	A previous order, dated					
		a.m. for Xyloxin					
	indicated to give	5 milliliters (ml) orally					
	_	before meals was noted					
	1	s order portion of the					
	clinical record.	The medication label on					
	the bottle of med	lication indicated to					
	administer Xylox	kin Oral Suspension 5 ml					
	1	before meals and at					
	bedtime.						
	In an interview w	vith LPN #2 on 5-26-11					
		N #2 indicated she had					
	1	vloxin to Resident #30					

l	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE SURVEY COMPLETED
		155742	A. BUILDING B. WING		05/27/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		l l	AMMERS PIKE	
ST ANDF	REWS HEALTH CAN	MPUS	BATES'	VILLE, IN47006	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG		ration observation the	IAG		DATE
	previous day.	ation observation the			
	previous day.				
	A policy entitled	, "Guidelines for			
		r Reporting," with an			
	effective date of 11-10 was provided on				
5-26-11 at 3:50 p.m. by the Director of		o.m. by the Director of			
	Health Services.	This policy indicated to			
	take whatever immediate action to protect				
	the resident, to notify the physician and				
	family of the event, to document the error				
and to monitor the resident for untoward					
	reactions.				
	A 1' ('.1 1	"O 1M 1" ("			
		, "Oral Medication			
	· · · · · · · · · · · · · · · · · · ·	with an effective date of			
	_	ided on 5-25-11 at 9:45 etor of Health Services.			
	•	ng of procedures, section			
		pour the correct amount			
	into medication of	_			
		oup.			
	3.1-35(g)(2)				
	, ,				
F0387	The resident must	be seen by a physician at			
SS=D	least once every 3	0 days for the first 90 days			
		nd at least once every 60			
	days thereafter.				
		considered timely if it			
		an 10 days after the date			
	the visit was requi	red. ew and record review, the	F0387	F387 Frequency and Timelir	ness 07/01/2011
	Dascu on intervie	w and record review, the	1.030/	. 557 1 Toquency and Timelii	0//01/2011

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155742	B. WIN			05/27/2	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER				AMMERS PIKE		
	REWS HEALTH CAN	MPUS			VILLE, IN47006	-	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1 *	ensure physician visits			of Physcian Visits1. Physician visited and completed	an	
		every 60 days in 1 of 3			assessment on resident #33	on	
	records reviewed	for timeliness of			1-6-11. 2. Director of Health		
	physician visits i	n a sample of 12.			Services or Designee will rev	/iew	
	(Resident #33)				all residents medical record t		
	Findings include	:	all residents medical record assure timely MD visit as p policy by July 1, 2011.3. D of Health Services or Desig will re-inservice physican a		ector ee		
	Resident #33's clinical record was reviewed on 5-24-11 at 2:15 p.m. Her diagnoses included, but were not limited				medical records nurse in reg		
					to policy of physcian visits by	/ July	
					1, 2011.4. Medical		
	to, Alzheimer's disease, dementia,				Records/Designee will track physcian visits to assure time	alv ac	
	hypertension (high blood pressure), severe				per policy. This audit is ongo	-	
		vascular accident			per peney. The dual is ong	,,,,g.	
	· ·						
	l `	ive heart failure (fluid					
	1 ^	the heart associated with					
	l •	problems), aspiration					
	*	ch 2011), and a history of					
	falls.						
	The physician pr	ogress notes indicated the					
	physician visited	on 8-20-10 and not again					
	until 1-6-11. Thi	is resulted in 108 days					
	between physicia	nn visits.					
	To token to tel	de Dissertes CH 44					
		the Director of Health					
	` ′	on 5-25-11 at 12:40 p.m.,					
		could not find any					
		cian's visit for October					
	2010 [date the ne	ext physician's visit was					
	due.] The DHS i	indicated the physician is					
	normally "like cl	ockwork" in regards to					
	timely physician	visits and she did not					
	know why this ha						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011	
	PROVIDER OR SUPPLIER		1400 L	ADDRESS, CITY, STATE, ZIP CODE AMMERS PIKE SVILLE, IN47006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0425 SS=D	3.1-22(d)(1) 3.1-22(d)(2) The facility must premergency drugs are residents, or obtain described in §483. facility may permit administer drugs if under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of the facility must error a licensed pharm consultation on all pharmacy services. Based on observation of the facility must error all pharmacy services administered phymedications durin observation in who observed for corrections.	rovide routine and and biologicals to its in them under an agreement 75(h) of this part. The unlicensed personnel to state law permits, but only supervision of a licensed procedures that assure the procedures that assure the procedures that assure the procedures and biologicals to each resident. Imploy or obtain the services macist who provides aspects of the provision of an interview and the facility failed to ensure and the medication pass in the facility sician ordered and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the medication pass in the facility failed to ensure and the fa	F0425	F425 Pharmaceutical Service-Accurate Procedure RPH.1. On May 26, 2011, Director of Health Services of Designee reviewed medical record for residents #9 and #30. a. Resident #9 Medication error report was completed for 5-17-2011 on 5-24-2011. Resident receive proper dose of medicaton or 5-24-11. MD and family notified of the completed in the completed in the completed in the completed in the complete in the comp	o7/01/2011 s, or ed the fied for
	_	-24-11 at 7:25 a.m., LPN		family notified. New label wi correct dosage was placed of	th

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER		X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILDING	00	COMPLETED
		155742	Į.	B. WING		05/27/2011
NAME OF I	PROVIDER OR SUPPLIER	" }	<u>.</u>	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
					_AMMERS PIKE	
ST AND	REWS HEALTH CAI	MPUS		BATES	SVILLE, IN47006	
(X4) ID		STATEMENT OF DEFICIENC		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED B		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFOR		TAG	DEFICIENCY)	DATE
		providing the morn	٠ .		medication on 5-25-11.2. D of Health Services or Design	
		Resident #9. After th			will compare all MAR's with	
	medication observation was completed, a				original MD orders on all	
	medication reconciliation was conducted			residents by July 1, 2011.3.		
	1	edications were give			Director of Health Services	
	comparison to what medications had been				Designee will re-inservice all nurses to include LPN#1, #2	I
	ordered by the physician. The physician				QMA's on medication policy	I
orders indicated Resident #9 was to				emphasis on the five rights		
receive Vitamin D-2 50,000 units once			ce		medication pass to minimize	
	weekly by mouth. On the Medication				by July 1, 2011.4. Ten MAR	's per
	Administration Record (MAR) this			week will be compared with physician orders to assure		
	medication was identified to be given		1		medications received as ord	ered.
	each Tuesday upon rising. This				Audits will continue until 100	
	1	not identified as beir	ng		compliance is reached times	
		5-17-11 as the date l	٠ .		three consecutive months.	
		to identify which da			results will be reviewed by C committee and need for fur	I
		medication; however			auditing will be determined I	
	1 "	re placed within the l			committee.	
		been administered.				
		or Report," dated 5-2				
		n D-2 50,000 units 1				
		nce weekly on Tuesd				
	had been omitted	•	ays			
	nad been omitted	1 011 3-1 /-2011.				
	2. During the m	edication page				
	_	-25-11 at 11:35 a.m.				
			•			
		erved providing the a desident #30. LPN #				
			I			
		ministering 5 millilit				
	1 -	d to Resident #30 pri	or to			
	her meal.					
	A.C					
		tion observation was				
	completed, a me	dication reconciliation	on			
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete	Event ID: 5JM	1111 Facilit	y ID: 004671 If continuation	sheet Page 25 of 36

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO.	NSTRUCTION 00	COMP	LETED	
11.15 12.11.	or conduction	155742		LDING		05/27/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				MMERS PIKE		
ST ANDF	REWS HEALTH CAN	MPUS		1	/ILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		verify what medications					
	"	mparison to what					
		been ordered by the					
		physician orders indicated					
		:55 a.m. a clarification					
		the Xyloxin to 2 tsp.					
		milliliters) by mouth					
	1	5 minutes before meals					
		A previous order, dated					
		a.m. for Xyloxin					
	1	5 milliliters (ml) orally					
	1	before meals was noted					
		s order portion of the					
		The medication label on					
		lication indicated to					
	· ·	kin Oral Suspension 5 ml					
	<u> </u>	before meals and at					
	bedtime.						
	In an interview v	vith LPN #2 on 5-26-11					
		N #2 indicated she had					
	· ·	vloxin to Resident #30					
	-	ation observation the					
	previous day.						
	A policy entitled	, "Guidelines for					
	Medication Error	r Reporting," with an					
	effective date of	11-10 was provided on					
	5-26-11 at 3:50 p	o.m. by the Director of					
	Health Services.	This policy indicated to					
	take whatever im	mediate action to protect					
	the resident, to n	otify the physician and					
	family of the eve	ent, to document the error					
	and to monitor th	ne resident for untoward		_			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED		
155742 B. WING			B. WING		05/27/20	011
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				AMMERS PIKE		
ST ANDR	REWS HEALTH CAN	MPUS	BATES	VILLE, IN47006		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second se	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	reactions.					
		, "Oral Medication				
		with an effective date of				
	2-1-10 was provi	ided on 5-25-11 at 9:45				
	a.m. by the Direc	ctor of Health Services.				
	Under the heading	ng of procedures, section				
	B-1 indicated to	pour the correct amount				
	into medication of	cup.				
	3.1-25(b)(3)					
	3.1-25(b)(9)					
	3.1 25(0)(3)					
R0000			1			
	The following re	sidential findings were	R0000	R117 Personnel1. Staff;		
	cited in accordan	nce with 410 IAC 16.2-5.		CNA's #1, 2, 3, 4, 7, LPN #5		
				QMA #6 and the Activity Dire will be trained on First Aid by		
				1, 2011.2. all other staff that		
				scheduled on Residental File		
				were reviewed to assure cur	rent	
				first aid by the Director of He		
				Services/Designee by July 1		
				2011.3. All Depart Leaders		
				Include Payroll were inservice on the policy on First aid train		
				by Director of Health	ا ق	
				Services/Designee by July 1	,	
				2011.4. Director of Health	.	
				Services or Designee will mo	onitor	
				all employee files that work Residental to assure continu	_{iina}	
				education in first aid. These	· ·	
				audits will be ongoing. All re		
				will be reviewed by the QA		
				committee to assure complia	ance.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID: 004671

If continuation sheet

Page 27 of 36

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/27/2011
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS			1400 LA	ADDRESS, CITY, STATE, ZIP CODE AMMERS PIKE VILLE, IN47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0117	qualifications, and applicable state la twenty-four (24) he unscheduled need services provided. and training of star required to provide the residents. A m staff person, with certificates, shall be (50) or more residential administration of none (1) nursing stall times. Resident hundred (100) res residential nursing of medication, or be (1) additional nursion duty at all times (50) residents. Per only those duties for perform. Employed written job description. This State Reside as evidenced by: Based on record facility failed to be training for 8 of the reviewed. This contential to affect the service of the state of the	Is of the residents and The number, qualifications, If shall depend on skills Is for the specific needs of Inimum of one (1) awake Current CPR and first aid Is eon site at all times. If fifty It is ents of the facility regularly Inursing services or Inedication, or both, at least It is fifty enders on shall be on site at It is facilities with over one It is ervices or administration It is ervices or administration It is entitled to the interview and interview the It is ensure staff had first aid It is employee records It i	R0117	R117 Personnel1. Staff; CNA's #1, 2, 3, 4, 7, LPN #5 QMA #6 and the Activity Dire will be trained on First Aid by 1, 2011.2. all other staff that scheduled on Residental File were reviewed to assure cur first aid by the Director of He Services/Designee by July 1 2011.3. All Depart Leaders t Include Payroll were inservic on the policy on First aid trai by Director of Health Services/Designee by July 1 2011.4. Director of Health Services or Designee will mo all employee files that work	r July are es rent alth , o ed ning

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671

If continuation sheet

Page 28 of 36

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/27/2	LETED
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS			B. WIIN	STREET A	AMMERS PIKE VILLE, IN47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	A policy and proceed Care", with a last was provided by records on 5/27/1 policy included, "Emergency Care adequate responsemergencies. Powill receive approareAt least on trained in first aid (cardiopulmonary management of proceeding to the coordinator provemployees, inclusive the conducted on 5/2 employee record of the staff were CNA's #1, 2, 3, 4 and the Activity During an intervipulation, the Payroll provided the employees just we employees just we employees just we	cedure for "Emergency treview date of 12/29/10, Employee # 9/medical 11 at 5:34 p.m. This but was not limited to, the Purpose: To assure the to resident licy statement: Residents opriate emergency to enduty staff will be do and CPR to resuccitation) for early problems" 103 p.m., the Payroll prided a list of all current ding 74 nursing staff. 105 cord review was 107/11 at 10:30 a.m. The review indicated 8 of 8 not certified in first aid; 107, LPN #5, QMA #6, Director. 106 cordinator, who ployee records, indicated: current information we do first aid. Yes, we knew the expired. Several tent through the CPR		TAG	Residental to assure conti education in first aid. The audits will be ongoing. All will be reviewed by the QA committee to assure comp	nuing se results	DATE
	training, but we o	don't have the cards back.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671 If continuation sheet

Page 29 of 36

AND PLAN OF CORRECTION IDENTIFICATION N		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155742	B. WING		05/27/2011
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS			1400 LA	ADDRESS, CITY, STATE, ZIP CODE AMMERS PIKE VILLE, IN47006	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R0298	(2) A consultant ph employed, or unde	he first aid training." narmacist shall be er contract, and shall: for the duties as specified			
	in 856 IAC 1-7; (B) review the drug practices in the fact (C) provide consul procedures of order and disposing of drecord keeping; (D) report, in writin his or her designed dispensing or adm (E) review the drug receiving these se sixty (60) days.	g handling and storage cility; tation on methods and ering, storing, administering, rugs as well as medication eg, to the administrator or any irregularities in inistration of drugs; and g regimen of each resident rvices at least once every	P.0208	R298 Phamaceutical Service	es1 06/04/2011
	the facility failed regimen review v residents at least affected 3 resider sample of 7 revier regimen review. # 61)	review and observation to ensure the pharmacist was completed for every 60 days. This ints in the residential ewed for pharmacy (Resident # 52, # 55, and d: 9:45 a.m., the clinical	R0298	Resients #61, #52, & #55 received pharmaceutical rev on 6-4-2011.2. all Residentia residents received pharmaceutical review on 6-4-11.3. Director of Health Services or Designee will re-inservice all nurses on pharmaceutical services poli with an emphasis on timely review.4. Director of Health Services or Designee will rev five clinical records every we assure timely pharmacy revieuntil 100% compliance times	iew al ccy view eek to eew

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5JM111

Facility ID:

004671

If continuation sheet

Page 30 of 36

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPI 05/27/2	LETED
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS			J. Water	STREET A	AMMERS PIKE VILLE, IN47006		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
TAG	record review for the resident was a limited to the following hypertension, dia fibrillation, hyperartery bypass surfaction of the Phregimen review of the Phregimen review on 5/26/11 at 9:1 pharmacy review resulting in 86 da Review of physical dated 1/14/11, in rehab for recover Pharmacist regimen 12/19/10 and 5/1 unit p [after] host date on this note. During an interview on 5/27/11 at 9:1 indicated that he hospital and sperhealthcare side for returned to his as	Resident # 55, indicated admitted with, but not lowing diagnoses: abetes mellitus, atrial rlipidemia, and coronary gery in January 2011. administers all of the ations. The armacy Consulting drug notes for Resident # 55, 5 a.m., indicated as on 6/5/10 and 8/31/10, anys between reviews. The armacy and physical dicated resident # 55 is in any from surgery. The review note between 10/11 indicated, "-to HC p [hospitalization]", no see with Resident # 55, 2 a.m., the resident came back from the		TAG	three months. All results were viewed by the QA commassure compliance.		DATE
	record review for	9:15 a.m., the clinical Resident # 61, indicated admitted with, but not					

Facility ID:

PRINTED: 06/21/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155742	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 05/27/2	ETED
NAME OF PROVIDER OR SUPPLIER ST ANDREWS HEALTH CAMPUS			14	400 LA	DDRESS, CITY, STATE, ZIP CODE MMERS PIKE VILLE, IN47006	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Diabetes mellitus macrolytic anem reflux disease, ar staff administers medications.						
	regimen review r on 5/27/11 at 5:2 pharmacy review and 8/31/10, resu reviews. The pha notes indicated re	rs completed on 6/5/10 alting in 86 days between rmacy regimen review eviews completed on 8/11, resulting in 69 days					
	record review for the resident was limited to the fol Gastroesophagea atypical chest par osteoarthritis, and pulmonary diseas administers resid her nebulizer me	11:30 a.m., the clinical Resident # 52, indicated admitted with, but not lowing diagnoses: I reflux, hypertension, in, diastolic dysfunction, d chronic obstructive se. Facility staff ent's medications except dications, which she has tion evaluation for.					
	regimen review r on 5/27/11 at 5:2 pharmacy review	narmacy Consulting drug notes for Resident # 52, 5 p.m., indicated as completed on 6/5/10 alting in 86 days between					

004671

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155742	B. WING		05/27/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		1400 LA	AMMERS PIKE		
	REWS HEALTH CAN	MPUS	l l	VILLE, IN47006		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	-	rmacy regimen review				
	•	on 12/19/10 and 2/28/11,				
	resulting in 69 da	ays between reviews.				
		35 p.m. a policy entitled,				
	_	A-105 Policy"was				
	reviewed. The p	olicy indicated, "Policy				
	Title: Medication	n and Treatment				
	Records", "Polic	y Statement:A				
	consultant pharm	nacist will review the				
	drug regimen eve	ery 60 days if staff				
	administers medi	ication."				
R0410	completed within the admission or upon forty-eight (48) to a result shall be reconsidered induration with the by whom administ (f) For residents who documented negative result during the phonormous months, the baselist should employ the step is negative, a performed within confidered the first test. The testing will depend to the tuberculosis. (g) All residents who to the tuberculin shave a chest x-ray	uberculin skin test shall be hree (3) months prior to a admission and read at seventy-two (72) hours. The orded in millimeters of a date given, date read, and ered and read. The hohave not had a tive tuberculin skin test receding twelve (12) ine tuberculin skin testing two-step method. If the first a second test should be one (1) to three (3) weeks The frequency of repeat d on the risk of infection with the have a positive reaction kin test shall be required to a and other physical and ations in order to complete				
	a diagnosis. Based on record the facility failed	review and interview, I to complete TB	R0410	R410 Infection Control1. Residents #73, #49 & #61 hacurrent TB Mantoux by July	•	
					· · · · · · · · · · · · · · · · · · ·	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155742 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1400 LAMMERS PIKE ST ANDREWS HEALTH CAMPUS BATESVILLE, IN47006 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 2011.2. Director of Health (tuberculosis) Mantoux testing at the Services or Designee will monitor required times. This affected 3 of 7 all medical records for current TB residents reviewed for TB Mantoux Mantoux and second step (where testing in the residential sample of 7. applicable) by July 1, 2011. 3. Director of Health Services or (Resident #49, Resident #61, and Designee will inservice all nurses Resident #73) by July 1, 2011 on the TB policy.4. Director of Health Findings include: Services or Designee will monitor all residents medical records ongoing for compliance. 1. On 5/24/11 at 11:15 a.m., review of the clinical record of Resident #73, indicated the resident was admitted with, but not limited to the following diagnoses: Chronic obstructive pulmonary disease, rheumatoid arthritis, hypertension, diabetes type II, Alzheimer's disease with disturbance of mood, and depression. Review of a Radiology report provided by executive director on 5/25/11 at 11:23 a.m., indicated Resident # 73 had a "TB skin test L [left] forearm on 6/25/10" and "6/28/10 PPD 0 mm [millimeters] induration". The 2nd step TB Mantoux test was not found in the clinical record. During an interview with the DHS [Director of Health Services] on 5/25/11 at 10:30 a.m., she stated,"we inadvertently missed the second step TB Mantoux on (name of resident)." 2. On 5/25/11 at 11:30 a.m., review of the clinical record of Resident #49, indicated the resident was admitted with, but not

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155742	B. WIN			05/27/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			AMMERS PIKE		
ST AND	REWS HEALTH CA	MPUS			VILLE, IN47006		
			_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILIACI)		DATE
		lowing diagnoses:					
	Congestive hear						
	insufficiency, hy	pertension, coronary					
	artery disease, an	nd depression.					
	Review of Resid	ent # 49's immunization					
		culosis summary record,					
		at the resident had an					
		oux test on 1/2/10 in the					
		rm] and read on 1/4/10					
		ration, a 2nd step TB					
		s completed on 1/16/10					
	in the LFA [left the	forearm] and read on					
	1/18/10 with 0 m	nm induration. The next					
	TB Mantoux test	t given was documented					
	as 2/22/11 in the	•					
		s to the results in					
		duration or nurse					
	1 -	nnual TB Mantoux was					
	due in January 2	011.					
	3. On 5/26/11 at	t 9:15 a.m., review of the					
	clinical record of	f Resident # 61, indicated					
	the resident was	admitted with, but not					
		lowing diagnoses:					
		s type II, hypertension,					
		• • • • • • • • • • • • • • • • • • • •					
	macrolytic anemia, gastroesophageal reflux disease, and osteoporosis.						
	i remux disease, al	na osteoporosis.					
		ent # 61's immunization					
		culosis summary record,					
	indicated the res	ident had an initial TB					
	Mantoux skin te	st on 1/3/10 in the RFA					
	[right forearm] a	nd there was 0 mm					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155742	A. BUILDING B. WING		05/27/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	1
	REWS HEALTH CAN			AMMERS PIKE VILLE, IN47006	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	T	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		5/10. The 2nd step TB			
		s completed on 1/18/10 0 mm induration on			
		ident's annual TB			
		I not been given at the			
		w. The annual TB			
		January 2011 according			
		original admission date of			
	1/4/10.				